NUCC/NUBC Meetings in Baltimore, August 2010

By Amy Costello and Marjorie Greenberg

NUCC Meeting

Update on NCVHS Subcommittee on Standards Meeting

The NCVHS held a hearing on operating rules and health plan ID on July 19-21. At this point, comments were still being received. Letters with recommendations will be prepared for September 15-16 NCVHS meeting.(Both letters subsequently were approved at the NCVHS meeting.) NCVHS is aware of competing priorities and the strain on IT resources.

1500 Prototype Subcommittee Report

The NUCC meeting was primarily focused on the presentation of several proposed options for revising the 1500 form. The NUCC would like to avoid any confusion or premature assumptions about changes to the form, and thus the details of the meeting and the proposed prototypes of the forms are not being shared.

At a high level, three options for revising the professional claim were considered: a slightly revised 1500 form with modified instructions, a form that may blend elements of the 1500 and the UB-04, and a completely new 1500.

The work to revise the forms began two years ago. Last year, a survey was conducted to inventory industry needs for the form. At the March 2010 NUCC meeting, the possibility of using the UB to report professional claims was suggested. At that time, it was determined that a mapping of the data elements for each of the options would help inform the discussion.

At the NUCC meeting in August, workgroups discussed the options and determined that the UB-1500 option would be removed from the possible choices because of important differences between the two claim forms and respective users of the forms. Discussion about the pros and cons of the completely new 1500 will resume at the September 2010 NUCC call.

NUCC is by no means finished with draft work that has been started and has not made any decisions about the approach to take.

X12 Update

For guides purchased from WPC, errata will be made available for download (no detail about timing provided).

NUBC Meeting

Code Maintenance/Requests

The committee discussed a summary of the recent electronic ballot on Condition Code BP, which was created to denote that the claim may be a related to the Gulf Oil Spill. The Committee will wait to see the final Change Request (CR) from CMS before the manual is officially updated. However, a broader discussion ensued on the process of identifying these types of (emergency) coding requests. Ultimately, NUCC suggested that a subcommittee could start exploring the process for codifying disasters, and this may involve the engagement of other federal agencies in that process (e.g. CDC and CMS).

One committee member observed that with health reform and performance measurement and ACOs, we will have to be able to implement changes quickly to stay current and relevant. Subcommittee may be formed to resolve the issue of need for new condition codes.

Use of the "From" Date (FL6) and Admission Date

CMS Update/Communication Strategy about the "From" date may go out early next year; will have systems in place and be implemented in October 2011.

Medical/Nonmedical Code Sets and Effective Dates

Recent testimony was provided to NCVHS about a problem of implementing Point of Origin codes, and the discontinuation of Point of Origin Code 7 (Emergency Department). The NUBC specified the effective date as related to the date of discharge, whereas CMS issued an instruction using "date of service". Currently, under HIPAA, medical code sets follow one rule, while non-medical code sets follow a different rule. Clearinghouses use transaction date so claims were rejected. A consistent policy is needed for defining code sets across medical and non-medical data.

An option was proposed to include a preamble in UB manual that includes language explaining that effective dates are discharge dates unless otherwise specified. NUBC still needs a legal opinion to reconcile HIPAA regulations and NUBC.

CMS suggested that if there is a problem with operationalizing the HIPAA rule that was written ten years ago, then HIPAA operational rules need to be modified and solved. HIPAA language issue should not hinder doing business… particularly if there is consensus among providers and plans.

How do we address problem going forward…

- NUBC will consider implementing standard effective dates;
- NUBC will draft a letter to OESS to recommend changes to operating rules; challenge is that the language is in the regulation text which will require rule making and policy evaluation before it can be changed.
- Committee members recommended better communication from NUBC, and going forward, if we want to discontinue any codes, we should wait until the policy decisions are resolved between NUBC and OESS.

Rulemaking may take awhile; guidance would have a quicker turnaround. Ms. Doo indicated that consensus from providers and health plans on any modification would be part of the process.

Mr. Omundson commented that we knew from the beginning that this was a huge change and that there would be problems based on the nature of the change. We are planning on an aggressive approach with respect to the upcoming edit changes in from/through and admit dates.

NUBC will strive for the least disruption as possible as this change goes into effect.

Explanatory text could be added in the opening/introduction of the UB in terms of what effective dates mean, our philosophy on changes (stop using discontinued codes as soon as possible) and make sure that the Implementation Calendar is very clear. Mr. Arges noted that this is an opportunity to standardize how we define effective dates going forward. For the conference call next month, we can discuss language that we would want to include in the next manual as up front material.

New Condition Code P7 and Related Issues

When "7" was eliminated in Point of Origin, condition code P7 was created for "public health purposes only".

From NUBC Minutes:

There are other ways of determining this off the claim; but some state data gathering agencies (e.g. Florida) wanted these situations explicitly flagged because they track ED usage and their systems are not set up to easily determine this information. Any entity (usually a state data agency) that wants this reported would issue its own instructions to the hospital community; it is not for use on claims sent to payers. The PoO will continue to be reported. The Arizona data gathering agency (Arizona Department of Health Services - Bureau of Public Health Statistics) implemented condition code P7 for data reporting purposes (on a proprietary electronic format) effective 7/1/10. Their instructions to providers may not have mentioned that they should not report P7 on claims as intended by the NUBC. Mr. Arges commented that the introduction of P7 has created more of a problem than what it is trying to resolve. For claims, we laid out a methodology for determining whether the ER was involved. Other codes on the claim such as the ER revenue code (0450) and Priority of Admission code can be used as indicators; the bill type will tell you whether the patient was admitted.

A suggestion was made that P7 could be defined as "not required, but not rejected".

Another suggestion was made to eliminate the "public health reporting only" wording, indicating that if it is a valid code, we should not need to articulate the purpose, or restrict the use of the data for non-billing, for public health purposes only. For example, race/ethnicity and language are in the UB-04 as "public health reporting only" (PHR) and these elements are not needed for adjudication, but submitted to states and can be used for public health purposes and/or health services research, etc.

There is a history of elements that were originally PHR that ultimately were used for other purposes. Over the years, PHDSC has come forward to propose data elements that are not necessarily for adjudication but later become useful or have value to payers like e-codes, present on admission, etc.

New Condition Codes for Reoccurrences of Comorbid Conditions

CMS requested three new condition codes to specify a reoccurrence of acute comorbid conditions applicable for adjustments for End Stage Renal Disease (ESRD) patients, as required under the Medicare Improvements for Patients and Providers Act (MIPPA).

- Reoccurrence of GI Bleed comorbid category
- Reoccurrence of Pneumonia comorbid category
- Reoccurrence Pericarditis comorbid category

H3, H4 and H5 will be added to UB based on date of service (treatments on or after). This is a non-medical data set, but it is written into law and it is additive (not like code set issues above). The condition codes apply to bill type 072X only (ESRD).

(From NUBC Minutes) ACTION: Condition Codes H3, H4 and H5 Approved Effective January 1, 2011

The titles and definitions are as follows:

H3 - Reoccurrence of GI Bleed Comorbid Category

Code indicates a reoccurrence of GI bleed comorbid category limited for use in conjunction with ESRD PPS and applicable to 072x types of bill only.

H4 - Reoccurrence of Pneumonia Comorbid Category

Code indicates a reoccurrence of pneumonia comorbid category limited for use in conjunction with ESRD PPS and applicable to 072x types of bill only.

H5 - Reoccurrence of Pericarditis Comorbid Category

Code indicates a reoccurrence of pericarditis comorbid category limited for use in conjunction with ESRD PPS and applicable to 072x types of bill only.

MIPPA specifically states that ESRD PPS is effective for dialysis treatments on or after 1/1/11. Because this is a new code, date of service vs. date of claim initiation should have no effect on implementation. If the code is used on claims with dates of service prior to 1/1/11(regardless of when the claim is initiated) Medicare will adjudicate it under the current (pre-PPS) payment system. Effective January 1, 2011.

Three Day Payment Window Policy - Condition Code 51 for Outpatient Claims

The 3-day payment window requires a hospital to include on the claim for a beneficiary's inpatient stay, the charges for all outpatient diagnostic services and admission-related non-diagnostic services provided during the payment window. The "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010" requires attestation on outpatient claims that the non-diagnostic service provided within three calendar days prior to admission is not related to the admission to the inpatient stay This has been common practice and now it is required by law.

The CMS policy (law) effective date is June 25, 2010. The CMS implementation of the code is April 4, 2011. The NUBC effective date is April 1, 2011. First of the month is practice of NUBC. Claim could be submitted and resubmitted (based on submitted date after June 25, 2010). Date of transaction keeps CMS in compliance.

(From NUBC Minutes) ACTION: Condition Code 51 Approved Effective April 1, 2011

> 51 - Attestation of Unrelated Outpatient Non-diagnostic Services
>
> The hospital attests that the outpatient non-diagnostic service provided within 3 calendars days (1 calendar day for nonsubsection (d) hospitals) prior to the admission is not related to the admission to the inpatient stay, and is for use on outpatient claims only.

Miscellaneous Point of Origin Code Maintenance

Summary of Proposed Changes approved effective immediately:

1. Because an order to admit or a physician referral is immaterial to Point of Origin, "was referred" was replaced with "presented" for consistency with previous revisions of other codes.
2. The usage note for Code 1 has been updated to include home health patients.
3. Assisted Living Facilities have been added to Code 5 for consistency with Patient Discharge Status Code 04.
4. NUBC approved bill type 014x (Hospital - Laboratory Services Provided to Non-patients) be exempt from reporting Point of Origin. It is currently designated as outpatient in FL04. Effective April 1, 2011.
5. NUBC approved edits to the wording of examples and change to outpatient verbiage to address unclear wording of home health care services; language changes were not substantive, just for clarification. Effective immediately.
    - Codes 5, 6, and 8, instead of "referred", the term is "presented".
    - "F" needs to be from "hospice facility" to stay true to the intent of point of origin (location/institution), and the rest of the description goes away.
    - Change "transferred" to "presented" in 8.

The current Point of Origin reporting requirement on the UB-04 is required and situational on the 5010 837 (but "required for all inpatient and outpatient services"). It could be argued that a lab specimen is neither inpatient nor outpatient. Thus, the NUBC proposed that bill type 014x (Hospital – Laboratory Services Provided to Non-patients) be exempt from reporting PoO.

(From NUBC Minutes) ACTION: Approved Effective April 1, 2011

> This bill is currently designated as outpatient in FL04. An exception will be added to the list (on page 5 of 9 of FL04. The reporting requirement note above will also be modified accordingly.
>
> **Reporting:** • UB-04: Required except for Type of Bill 014x.
>
> • 004010/004010A1: Situational. Required for all inpatient admissions. Required on Medicare outpatient registrations for diagnostic testing services.
>
> • 005010: Situational. Required for all inpatient and outpatient services except for Type of Bill 014x. (Note: Therefore required on all bill types marked "IP"and "OP" per FL 04 Pages 3-4, except for Type of Bill 014x which is exempt from reporting Point of Origin.)
>
> Note: In addition, CMS agreed to drop the condition in its instructions that Code 9 is not appropriate for outpatient claims to be consistent with the UB-04; "9" will be a valid code on all claims.

Fractional Values for Units Field (FL46)

CMS requested to designate fractions of units. 837I is very open to allow for decimals; maximum allowed to the right is 3. CMS is requesting at least one position to the right in response to upcoming legislation about ambulance travel distance. This will increase consistency with 5010 (and 837). . NUBC approved fractional values for units fields with no more than 3 digits to right, no leading zeroes, and floating decimal. Effective January 1, 2011.

Revenue Code 0636 Discussion

CMS issued a proposed rule supporting billing all drugs and biologicals with HCPCS codes under revenue code 0636. Concern was expressed about drugs that may not have a HCPCS code (or can only be reported under "unlisted" generic HCPCS codes). NUBC and NUBC members were encouraged to send in comments on the NPRM. Comment period ends August 31. Final rule is in November.

Patient Discharge Status Code FAQ #36: difference between residential care and assisted living care

Terminology means the same thing, but states refer to the facilities with different names.

NUBC proposed changing language to better define codes for RC and ALF (1 and 4), and make the distinction between supportive care at home or supportive care at any other facility designated to provide care; and the recommendation is to use 01 when the patient is receiving care/services at home and use 04 when the patient's residence is a facility.

State Issues

While the UB manual will be updated annually, the schedule for effective dates is largely based on emergencies and legislation. NUBC will send a letter inquiring about potential process for CDC and CMS to coordinate federally (and maybe at the state level) before approaching NUBC. Arges will send letter to NUBC members before sending to CDC and CMS.